

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/09/2014
NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{G 000}	<p>INITIAL COMMENTS</p> <p>This visit was a second (2nd) revisit for the Federal recertification survey completed on 6-19-14 that resulted in an extended survey; first revisit survey was on 07-31-14.</p> <p>Survey Date: 12-09-14</p> <p>Facility #: 012338</p> <p>Medicaid Vendor #: 201018830</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>One (1) condition and two (2) standards were found to be corrected during this survey.</p> <p>Guardian Home Health, Inc. was found to be in compliance with the Conditions of Participation 42 CFR Part 484.</p> <p>Guardian Home Health, Inc. is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 07-01-14 due to being found out of compliance with Conditions of Participation 42 CFR 484.10 Patients's Rights, 42 CFR 484.18 Acceptance of patients, Plan of Care, and Medical Supervision, 42 CFR 484.30 Skilled Nursing Services, 42 CFR 484.36 Home Health Aide Services, and 42 CFR48 Clinical Records.</p> <p>Current Census: 12 Home Health Aide Only Patients 4 Home Health Aide with shared services for Personal Care</p>	{G 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 Attendant Services 16 Total Quality Review: Joyce Elder, MSN, BSN, RN December 10, 2014	{G 000}			